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The ultimate guide for surviving a home health site survey

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Prepare for your home health survey

CMS expects home health agencies (HHAs) to have substantial and continued compliance with the Medicare Conditions of Participation (CoPs) and for agencies to take the initiative and responsibility for continuously monitoring their own performance to sustain compliance. With this expectation in mind, preparing for site surveys should not be considered a cyclical event. Instead, focus on ensuring your clinical, quality, and operational oversight systems promote both continuous compliance and a constant state of survey readiness.

Leadership and owners: Identify your core survey response team

Putting together a solid plan for survey preparedness starts with identifying your core survey response team. Look at not only your key leadership in the organization, but also for opportunities to develop field and office staff, with the goal in mind of devising a survey preparedness plan that will involve staff on all levels and promote the importance of creating an organization that continuously monitors compliance and improves quality.

Identify a survey lead, as this is a critical role of the response team and the key contact for the surveyors. They guide the response team activities, respond to requests for documentation, and manage all hard copies given to the surveyors.

It's important to choose a leader who is knowledgeable about the operations, organized, cool under pressure, and able to effectively lead others. In addition to the core survey lead, it is also important to identify key leadership or resource owners for each core functional area and audit system.

Understand and organize survey documents

The best defense is a great offense. When a surveyor arrives onsite, the first hour tends to be the most intense and anxiety-inducing for staff. Multiple documents and reports will be requested, in addition to patient and personnel records. There will also be a need to urgently schedule field visits with staff for the surveyor(s).

It's not uncommon for even the most experienced and knowledgeable staff to suddenly forget how reports are run or where important documents are located. By being prepared to expediently provide any requested document or report, HHAs can set the tone for a successful survey and provide great direction for staff, helping to reduce confusion and effectively manage anxiety. This also demonstrates to the surveyor that the HHA is efficient and organized and helps support staff on the front lines.

The types of documents requested can vary significantly depending on the type of survey. Promoting a continual state of survey readiness starts with incorporating both a system for centralizing survey documents into a known location and having a monitoring process in place to make sure all survey documents are reviewed and updated on a scheduled, consistent basis.

Understanding what reports to run for the survey is also very important, as surveyors will expect this information upon entrance to your agency, so that field visits can be scheduled and records can be selected to audit. Here are some of the most common survey reports that will likely be requested when the surveyors arrive:

- Unduplicated admissions – last 12 months
- Active patients report that identifies SOC/episode dates, primary diagnosis and disciplines provided (some surveyors may also request identification of payors)
- Discharged patients with discharge reason for last 12 months
- Active employees (including contracted staff) with titles and DOH
- List or schedule of patients scheduled to be seen for home visits during survey: A schedule of planned patient visits is used by clinical leadership and/or surveyors to identify patients for survey home visits. If your agency has weekly staff meetings or team conferences, it is best practice to identify potential survey visit patients and incorporate them into supervisory field visits and tracer audits during your survey window.

MatrixCare clients can contact customer support with report questions or needs.

Review and update policies and procedures

Policy review is not only an important component of survey preparedness, but also a critical administrative activity — as the purpose of policies and procedures is to provide standardization in daily operational/clinical activities, assuring local, state, federal, accreditation and organizational requirements are understood and followed.

Policy and procedures communicate to employees the desired outcomes of the organization as well as help employees understand their roles and responsibilities within the organization — all while providing the framework for the delivery of safe and cost-effective quality care.

HHAs should expect various policies and procedures to be requested during the course of a survey based on findings as they occur, and observations made regarding care provided during home visits. This can present a significant challenge, as depending on the agency and organizational structure, policy and procedures can be quite expansive. Having a solid annual review system in place, and a consistent mechanism to track review and revision dates, is especially critical.

A best practice to incorporate into annual review and also to promote a consistent state of survey-readiness is to create a "top 25 list" inclusive of common policies requested during surveys and policies that relate to HHA-known challenge areas (as identified within your QAPI program). Start with identifying a list of 25 priority policies to review for content and verify that they are updated to follow local, state and federal regulatory rules, as well as reflective of agency applicable accreditation standards.

Communicate revisions to staff on all levels and incorporate education of policy into all onboarding/orientation and ongoing educational activities and staff meetings. After tackling the first 25 priority policies, it becomes easier replicate the process, and to focus on the next 25. Each HHA's "top list" number may vary, depending on prior surveys and known challenge areas identified.

A great way to start your "top list" is by utilizing the Medicare CoPs as a crosswalk for key focus areas to assess your policy — since actual titles of policies vary by organization and some organizational policies may be organized and/or titled based on accreditation standards.

When performing the crosswalk, think about known challenge areas already identified for your

agency from past surveys and high-risk, high-volume areas identified within your QAPI program that are unique to your agency.

Anticipate that policies related to Level I and II standards (used to conduct standard and partially extended surveys) may be requested, such as:

- Patient Rights
- Comprehensive Assessment
- Care Planning, Care Coordination, Quality of Care
- Quality Assessment Performance Improvement (QAPI)
- Infection Control
- Skilled Professional Services
- Home Health Aide Services
- Organization & Administration of Services
- Clinical Records

Review and test emergency preparedness plan (EPP)

A major goal of emergency preparedness is to promote predicable staff behavior during an emergency.

Agencies should have a system in place to review and update the plan at least annually, inclusive of regulatory and policy requirements for training and testing to promote compliance.

Devise a plan to incorporate EPP training into initial orientation and ongoing trainings, and to practice and document training drills. For agencies that have a Safety Committee, incorporate emergency preparedness as a standing committee agenda item, and assign a lead to assure all testing and training activities are documented and the EPP remains updated and in a central location, accessible to all staff. It can also be helpful to incorporate an emergency preparedness component as a standing item at staff and leadership meetings throughout the year, setting the expectation for staff on all levels for the importance of promoting predictable behavior in emergency situations.

HHAs that effectively manage all aspects of training and testing of their plans have a higher likelihood that staff behavior will also be predictable during surveys, as staff on all levels should be able to effectively explain to surveyors how the HHA handles emergencies, and that they are aware of how and where to access the EPP.

Personnel records, education and competencies

It's important to have a system in place for auditing personnel records for regulatory, accreditation, and agency-defined policy requirements. You should be prepared to provide personnel records at any time during a survey and it is common for surveyors to request records for all direct-care staff observed during home visits, in addition to the records for the administrator and clinical manager/clinical supervisor

It is recommended to assign an "owner" who is responsible for the maintenance and monitoring of personnel records. When auditing personnel records, it's also helpful to have a tool that identifies the table of contents/order/sections within the personnel record, inclusive of annotations for all annual

required education/training, licenses/certifications, competencies, health testing, and direct in-field supervisory and/or annual evaluation components.

Build a data-driven QAPI program

CMS expects a robust, data-driven QAPI program that continually evaluates and improves care for all patients, with oversight by your Governing Body to ensure your program:

- Reflects the complexity of the organization and its services and involves all agency services (including those provided under contract/ arrangement).
- Focuses on indicators related to improved outcomes, including the use of emergency care and hospital admission.
- Takes actions to address agency performance across the spectrum of care, inclusive of prevention/reduction of medical errors.
- Maintains documentary evidence of the QAPI program and is able to demonstrate its operation to CMS surveyors.

CMS organizes the QAPI-related Conditions of Participation (CoPs) into five standards:

- Program scope
- Program data
- Program activities
- Performance Improvement Projects (PIPs) — HHAs are required to have at least one documented PIP
- Executive responsibilities of the Governing Body

Additionally, the CoP requirements encourage greater focus on infection prevention and control and expect providers to maintain and document an infection control program as an integral part of their QAPI Plans. Infection control programs must follow accepted standards of practice, including the use of standard precautions to prevent the transmission of infections and communicable diseases.

Your program should include methods for surveillance, identification, prevention and control, and investigation of infections and communicable diseases specific to care and services provided in the home. You should observe and evaluate services provided by all disciplines to identify sources or causes of infections/communicable diseases, as well as to track patterns and trends and identify ongoing training and competency needs.

Staff preparation: Pull it all together

Your survey preparation plan should involve prepping staff on all levels of the organization. Agencies should consider developing a "training and testing" component within the plan, much like the required training and testing involved with emergency preparedness. The more prepared staff are, the more confident they become while participating in the survey.

Be creative. Hold a survey survival skills fair, making it interactive and fun. Set up stations for hand hygiene, bag technique, trunk checks, mini-tutorials and scavengers hunts related to your EPP, QAPI plan and infection control. There could also be an interview station for practice questions as well as raffles and prizes.

Be consistent. Plan educational topics for scheduled staff and leadership meetings, focusing on key survey areas that often have deficiencies such as nursing, aide and professional assistant supervision requirements, home health aide services, care planning and care coordination, and patient rights.

Be visual. Set up visual displays of key performance metrics and QAPI indicators around the office. Generate some excitement by establishing a goal that all staff know what the agency is working on improving.

Practice mock survey activities. Mock survey activities can be a helpful tool for your organization as part of the testing component of your survey preparedness plan. Consider including the following areas within your next mock survey:

- Review QAPI Plan, Infection Control Plan and PIPs
- Audit survey documents/reports and ability to quickly access
- Review your EPP, ensure a documented drill
- Audit medical records and personnel files
- Perform field visits with tracer audits
- Practice survey interview questions with field/office staff
- Test your call tree

Implement and monitor an effective plan of correction

A plan of correction (POC) is the HHA's written response to survey findings, detailing the corrective actions to the cited deficiencies and specifies the date by which those deficiencies will be corrected. This plan is developed by the HHA and approved by CMS.

However, developing and implementing an effective and acceptable POC involves more than responding in writing to cited deficiencies and how to correct them. It requires the HHA to analyze all deficiencies identified and determine whether the underlying root-cause of each problem is isolated or a system issue. This then becomes the foundation for which to develop corrective actions that are inclusive of education, new policies, procedures and processes. These will not only correct each deficiency, but also assure compliance is both achieved and maintained by ensuring the underlying causes of problems do not recur and that lasting changes are made within the agency that will improve quality, safety and care delivery for all patients served.

Survey entrance

The process of developing and implementing an effective POC begins the moment a surveyor enters the building, much like the common home health philosophy that "discharge planning begins at admission."

Throughout the survey process, HHAs have the right to request clarification of any surveyor comments/statements or expressed observations, offer additional evidence of compliance to clarify and/or refute negative findings, and request resolution of conflicts from the State Agency (SA) and/or the CMS Regional Office (RO), if necessary.

Thus, it is important to continually "scribe" or document findings as they are identified, as well as any additional supporting documentation the HHA provided to clarify or refute negative findings, and the resulting outcome if applicable.

Daily survey debrief

Some surveyors may afford your agency the opportunity to sit with them for a brief daily exit conference to review their observations and findings from the day and provide your team an opportunity to clarify and bring forth more supporting evidence of compliance. Regardless of whether the surveyor team holds this daily exit conference, your agency survey response team should come together after the surveyors leave for a daily exit debrief.

During this debrief, the team can review observations and potential findings that occurred throughout the day. Documentation requested and provided can be reviewed, along with all scribe notes. If your agency was afforded the opportunity to send escorts on survey home visits, this is a great opportunity to discuss how those visits went.

If there is outstanding documentation the surveyors have requested and are waiting for, assign owners to pull it together and have it ready to be presented immediately the next morning. If there are known potential negative findings that can be clarified or immediately corrected and/or resolved, assign owners to work on next steps to do so the following day.

For known identified findings that will become cited deficiencies, assign owners to start work on corrective actions immediately. Your POC should start to be formulated and progress throughout your survey.

Survey exit

The exit conference generally consists of the surveyor(s), your leadership team, (administrator clinical managers/supervisors, quality managers) and any other staff that you choose to invite. The purpose is to provide a forum for the surveyor(s) to meet with your team to share observations and preliminary findings of the survey. This is an opportunity to exchange information, giving the surveyors the opportunity to voice concerns, and you the opportunity to respond.

This conference is also a forum for the surveyor(s) to educate your team on regulations, provide an informal review of preliminary findings and/or deficiencies, and advise you on what you can expect in regard to their final statement of deficiencies — providing instructions for completing and submitting your POC. It is important to have a scribe at the exit conference to document all information presented and exchanged, a summary of the informal review of deficiencies, and a summary of the next steps and instructions.

Post-exit debrief

After the exit conference convenes and the survey team has left the agency, HHAs can start to work on developing and implementing action plans immediately with a post-survey debrief. This involves briefly summarizing the preliminary findings and deficiencies reviewed to assure

all information and instructions presented by the surveyor(s) were accurately captured and documented. It's also a great time to forecast which standards may be cited in your final statement of deficiencies so that a focused plan can be initiated.

This debrief is an opportunity to assign action items for follow-up, and to start collaboration on the necessary steps to begin developing an effective POC. HHAs should not wait until they receive the final statement of deficiencies to determine necessary corrective actions.

Develop your POC

The POC process requires that you develop and implement policies to immediately remedy deficient practices and ensure that corrective actions are lasting. You must take the initiative and the responsibility of developing an effective POC and monitor performance to maintain compliance.

After the exit conference and the surveyor has left your agency, you can immediately begin the POC process, starting with determining root causes by first analyzing each deficiency to determine exactly what happened and why — focusing on the reason or root-cause of why the deficiency occurred will make it easier to address the needed corrective action elements within your POC. Helpful discovery questions to address include:

- Why did this occur?
- Is this related to a knowledge deficit?
- Was there something we should have been doing, but did not?

- Is this an isolated incident? (Isolated issue)
- What systems were lacking or incomplete? (Systemic issue)

Once the HHA has completed discovery and analysis of the identified deficiencies, determined the root-cause of each problem, and identified whether it is an isolated issue or a system issue, the HHA is now ready to write their POC — which needs to address the "who," "what," "how" and "when," following CMS' list of required elements that must be included in an acceptable POC, which are inclusive of:

- The plan for correcting the specific deficiency ("what" is the plan?). The plan should include the processes that led to the deficiency cited. This is where HHAs can interject their analysis of "why" the problem occurred).
- The procedure for implementing the acceptable POC for the specific deficiency cited ("how" will the deficiency be resolved, and "when" will it be corrected?). When including a timeframe

by which the deficiency will be corrected, take into consideration the nature and severity and time involved to effectively correct the problem.

- The monitoring procedure that will make sure that the POC is effective, and that the specific deficiency remains corrected and/or in compliance with regulatory requirements ("how" will effectiveness of the plan be measured?).
- The title of the person who is responsible for implementing the acceptable POC (the "who").

Take note: A general statement indicating compliance has been achieved or will be achieved will not be acceptable, as the POC must state exactly how the deficiency has been or will be corrected, and how the HHA will measure effectiveness of the corrective actions and assure it will not recur.

Format and submit your POC

The following are important considerations when formatting and submitting your POC:

- The HHA must prepare a POC even if it disagrees with the findings and/or is planning to request an Informal Dispute Resolution (IDR).
- Preparing a POC does not constitute an admission of wrong doing.
- Since the POC is public information, it should not contain any PHI, patient, or staff identifiers.
- The POC must be typed or written legibly.
- If using the CMS Form 2567, the POC for each deficiency must be typed or written in the right column of the statement of deficiencies, next to the appropriate tag number and violation/ deficiency.
- HHAs that elect not to write their POC on CMS Form 2567 can send it in as a separate attachment to the signed first page of the CMS Form 2567.

It is also very important for the HHA to confirm their POC has been both received and deemed acceptable, as there are serious consequences for not following submission requirements. Additionally, state and federal enforcement processes are independent of the POC process. Enforcement actions, such as terminations, may not be delayed even if the HHA's POC is late or needs revision to become acceptable.

Implement and monitor an effective POC

After the HHA completes and submits their written POC, the agency should have implemented their plan, which must be inclusive of establishing measures or systemic changes that will prevent the deficient practice(s) from reoccurring. A great starting point for implementation of the POC is review and education with staff on all levels of the organization. Hold an all-staff mandatory meeting and include the following:

- Overview of the survey findings and deficiencies cited.
- Recognition of staff and areas that performed well — be sensitive not to mention any staff by name when reviewing observations and negative findings on visits or clinical documentation.
- A review of each deficiency cited, along with the analysis of the root cause and associated POC.
- Training on new processes, policies or procedures as part of your POC.

- Expectations for outcomes, completion of required follow-up activities and performance to the plan, inclusive of understanding how the plan will be monitored to prevent problems from reoccurring.
- Documentation of the meeting: sign-in sheets, agenda, and copies of any handouts or educational pieces provided.

Be sure to incorporate ongoing training and testing activities throughout the initial first 90 days and then the year. Thoughtfully plan ongoing communications related to progress toward expected outcomes to make sure that staff on all levels understand the importance of performing to plan.

Supporting documentation

Organizing your supporting documentation with your POC is also a vital part of implementing and monitoring your plan. It also serves as supporting evidence that your plan was implemented and that deficiencies are corrected and continually monitored. Organization of all supporting documentation and data also provides a foundation by where your monitoring activities can be focused and incorporated into your agency QAPI program for long-term success.

Examples of supporting documentation include:

- Staff educational offerings and special trainings (agendas, sign-in sheets, handouts and training materials)
- Meeting minutes and sign-in sheets for all management/staff meetings that contain POC activities
- Data and audit tools
- New and/or revised policies and procedures, along with evidence of communication and training
- And any new or revised process or system needs documented and tested for the desired impact and outcomes the agency wised to achieve.

Centralized POC and supporting documentation

It is very helpful to keep all survey, POC and supporting documentation in one centralized location. Copies you should retain include:

- All documentation given to the survey team
- Notes taken during the course of the survey and exit conference
- List of patient home visits, and clinical and personnel records reviewed during the survey with identifiers as assigned by the survey team
- The Statement of Deficiencies (CMS Form2567) with signature
- The POC
- The CMS letter advising if the POC was acceptable
- Supporting documentation and evidence of implementation/monitoring of the plan

With a schedule and structure in place to review your POC, you can achieve zero recurrence and your POC can be used as a valuable management tool to help improve quality, safety, and care delivery for patients.

Monitoring

Remember, evaluation and monitoring of your POC should always extend past the correction dates to make sure the deficiencies will not recur. Monitoring systems should be well defined within your POC and may include such activities as audits of clinical and personnel records, supervisory visits to observe process, policy and procedures are followed, and demonstrated competencies are effective. Peer review audits with custom tools focused on targeted indicators of compliance can also be very effective, as staff learn and grow when reviewing documentation of their peers against a targeted audit tool.

Post training tests help to quantify comprehension and retention of critical concepts and instruction. And depending on the nature of the deficiencies cited, ongoing skills labs and competency testing might also be a valuable monitoring tool for the effectiveness of training. This is how your agency will take the initiative and the responsibility for continually monitoring your performance to make sure you remain in substantial compliance.

It is critical to have a system in place for reporting up to your Governing Body (and maintaining minutes) in regard to not only the results of the survey and resultant POC, but also progress to plan and dates deficiencies have been corrected — as your Governing Body is responsible for making sure that agency-wide quality assurance and performance improvement efforts address priorities to improve the quality of care and patient safety.

Integrate with your QAPI program to promote long-term success

The HHA's Governing Body has specific executive responsibilities, which include:

- An ongoing program for QAPI and patient safety is defined, implemented and maintained.
- The agency-wide QAPI efforts address priorities to improve quality of care/patient safety, and all improvement actions are evaluated for effectiveness.
- Clear expectations for patient safety are established, implemented and maintained.
- Any findings of fraud, abuse or waste are appropriately addressed.

Your QAPI program should always include your POC activities from survey on some level, as it is in natural alignment and can seamlessly be integrated. For instance, your QAPI program activities are expected to focus on high-risk, high-volume and/or known problem areas. Your survey assessed the care and services your agency provides and the findings from your survey have identified problem areas, some of which might have also included high-risk or high-volume areas.

The scope and focus of your QAPI program should include objective measures to demonstrate improved performance that is sustained over time — inclusive of assessing the quality of care provided and identifying and prioritizing opportunities for improvement. You have just implemented a POC which includes identified deficiencies and areas for improvement based on assessment of the quality of care provided, and it contains monitoring procedures with measurable indicators.

As part of a QAPI program, agencies are required to perform performance improvement projects (PIPs) that reflect the scope, complexity and past performance of the agency services and operations. These projects must be documented, inclusive of reasons for selecting the project and the measurable outcomes achieved. Take credit for all of your hard work in correcting deficiencies and achieving substantial compliance!

Your next steps should include scheduling a QAPI meeting to review your POC as the priority agenda item. Some deficiencies may have easily been corrected and others may need extensive ongoing monitoring. Prioritize each one and align supporting documentation with PIPs within your QAPI program.

The MatrixCare difference

At MatrixCare, we understand that when surveyors walk in the door, stress levels are high — and it can be challenging to live in a constant state of survey readiness. That's why we work hard to give you the tools you need to have peace of mind and make site surveys a breeze.

- Enjoy the functionality, automation, and guidance necessary to successfully manage your operations.
- Robust reporting allows you to identify clinical, financial, personnel and operational matters so you can manage your agency efficiently.
- Quality management and improvement tools enable you to focus efforts on meaningful improvement for a robust, data-driven QAPI program.
- Easy access to documents and data requested by surveyors.

Call 866.469.3766 to learn more, or visit matrixcare.com

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